MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Advanced Practice, Inc. on behalf of Baylor All Saints Medical Center 17101 Preston Road, Suite 180-S Dallas, Texas 75248-1331	MDR Tracking No.: M4-03-A382-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company P O Box 12029 Austin, Texas 78711-2029 Box 54	Date of Injury: Employer's Name: Simeus Holdings, Inc. Insurance Carrier's No.: 99A0000271957

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/21/02	10/25/02	Surgical Admission	$31,593.24	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"Our findings reveal this claim has not been paid according to the hospital fee guideline published by the Texas Workers Compensation Commission (TWCC). This claim in the amount of $67,719.79 is an inpatient surgical claim in which charges exceed $40,000, the stoploss threshold amount, however payment is not based on this methodology and we request you to review this for Medical Dispute Resolution as a Fee Dispute."

PART IV: RESPONDENT'S POSITION SUMMARY

"This dispute involves this carrier's payment for date of service 10/21/02-10/25/02 for which the requester charged $67,719.79 for a four day inpatient stay for services that were NOT unusually extensive or costly and for a patient that was not even in the ICU. Therefore, this carrier reimbursed the requester a fair and reasonable reimbursement for implantables and 4 days per diem based on the TWCC Acute Care In-Patient Fee Guideline. The requester was reimbursed this carrier's fair and reasonable reimbursement (estimated cost plus 10%) for implantables."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by the provider, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

	Michael Bucklin	03/18/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____